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Toward Outcome Measures in Occupational Therapy

Report of a Task Force
convened by the
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
and the
Canadian Association of Occupational Therapists

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TOWARD
OUTCOME MEASURES
IN OCCUPATIONAL THERAPY

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Research for this report was
conducted by Dr. Nancy Staisey,
in collaboration with the Task Force

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FOREWORD

As part of its Clinical Guidelines Program the Department of National Health and Welfare (DNHW) has been collaborating with health professionals in developing national guidelines for clinical procedures. Through its task forces, this Program offers coordination and leadership in improving quality of health care, a goal common to the Department and the professions.

One such task force, a joint project of DNHW and the Canadian Association of Occupational Therapists, developed national guidelines for the practice of occupational therapy, resulting in two reports: "Guidelines for the Client-Centred Practice of Occupational Therapy" and "Intervention Guidelines for the Client-Centred Practice of Occupational Therapy".

In 1986 a restructured task force was formed to address the development of measures to assess outcomes of occupational therapy. Toward this end, in collaboration with the Task Force, Dr. Nancy Staisey was engaged to conduct a survey to determine current practices of occupational therapy across Canada, including outcome considerations. This present report "Toward Outcome Measures in Occupational Therapy" is a result of this stage of the work and was prepared by Dr. Staisey in collaboration with the Task Force. The survey findings provide profiles of the profession in Canada, describing work settings, specializations, and outcome characteristics.

Plans for the next stage include the development and field testing of outcome measures. These will give greater scientific direction to the profession and increase its degree of professionalization.

Dr. Staisey's research expertise and competence hastened the Task Force's work. I thank her and the Task Force members for their cooperation and pioneering spirit. In particular, I thank the Chairperson, Thelma Gill, for her vision and commitment to this project.

Eve Kassirer

Medical Sociologist
Clinical Guidelines Program
Institutional and Professional Services Division
Health Services Directorate
Department of National Health and Welfare

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RECOMMENDATIONS

The Task Force recommends that:

1. a tool(s) to measure occupational therapy outcomes be developed based on the guidelines in this report;

2. the tool(s) reflect the three primary outcome objectives of occupational therapy to: prevent disability; promote, develop, and/or restore function; and maintain function;

3. the tool(s) to be developed to measure occupational therapy outcomes focus on the primary outcomes in the three areas of occupational performance (self-care, productivity, leisure) while recognizing the holistic contribution of the client's environment, motivation and roles, as well as the performance components (physical, mental, socio-cultural, spiritual) required for a particular function;

4. this report be circulated to occupational therapists across Canada to improve the quality of care they provide;

5. government agencies encourage and support the utilization of this report;

6. the Canadian Association of Occupational Therapists (CAOT) facilitate the formation of study groups to discuss this report and its implication for the profession; and

7. individuals, CAOT and provincial organizations forward comments and suggestions about this report to the Department of National Health and Welfare.

MEMBERS OF TASK FORCE

Thelma Gill, MEd, BScOT, OT(C) (Chairperson)	Occupational Therapist-in-Chief Clarke Institute of Psychiatry Toronto, Ontario, M5T 1R8
Eve Kassirer, MA (Coordinator)	Medical Sociologist Institutional and Professional Services Health Services Directorate Department of National Health and Welfare Ottawa, Ontario, K1A 1B4
Elizabeth Townsend, MAdEd, BScOT, OT(C) (Recording Secretary)	Assistant Professor School of Occupational Therapy Faculty of Health Professions Dalhousie University Halifax, Nova Scotia, B3H 3J5
Nancy Staisey, PhD, OT(C) (Researcher)	Price Waterhouse Management Consultants 180 Elgin, Suite 1100 Ottawa, Ontario, K2P 2K3
Sharon Brintnell, MSc, BOT, OT(C)	Chairman and Professor Department of Occupational Therapy Faculty of Rehabilitation Medicine The University of Alberta Edmonton, Alberta, T6G 2G4
Micheline H. Marazzani, MSc, BSc (ergothérapie), Erg(C)	Professeur agrégé Responsable du programme d'ergothérapie Ecole de réadaptation Faculté de médecine Université de Montréal Montréal, Quebec, H3T 1A8
Mary Ann McColl, MHSc, BScOT, OT(C)	Division of Occupational Therapy Department of Rehabilitation Medicine Faculty of Medicine University of Toronto Toronto, Ontario, M5T 1W5
Anne Opzoomer, MSc, BSC(OT), OT(C), OCOT	Registrar Ontario College of Occupational Therapists Toronto, Ontario, M5P 3B6

CHAPTER I: PURPOSE AND POTENTIAL USE OF OUTCOME MEASURES IN OCCUPATIONAL THERAPY

The development of outcome measures for occupational therapy is vital to the advancement of the profession, because of the objectives such measures can help the profession achieve. These objectives are to: 1) improve quality of care by providing the clinician with information on client outcomes which are useful for practice decisions; 2) demonstrate the effectiveness of occupational therapy to those funding these services; 3) demonstrate the effectiveness of occupational therapy to other care givers; and 4) clarify the role of occupational therapy. Thus, without valid and reliable outcome measures, these objectives and benefits cannot be realized by therapists and administrators.

The achievement of these objectives would increase the body of knowledge and skills unique to occupational therapy.

Over the past five years, the profession, through previous task forces on guidelines, has developed a conceptual framework and guidelines for the process stage of the client-centred practice of occupational therapy. This work forms a basis on which to develop outcome measures for occupational therapy.

Keeping in mind the objectives identified above, how can such outcome measures by used? With structural and process measures and guidelines for quality assessment in place, outcome measures can be used for numerous purposes including quality assessment and quality assurance. They can provide:

- tool(s) for client follow-up;
- tool(s) for individual client-centred evaluation of the effectiveness of intervention as the last stage in the client-centred process of practice;

- tool(s) for use in evaluating specific occupational therapy techniques, treatment modalities, strategies;
- tool(s) for use in periodic evaluations of occupational therapy programs;
- ongoing performance measurement systems of occupational therapy programs; and
- a data base which occupational therapy managers can use to develop standards or program goals.

These uses and applications of outcome measures will benefit the profession in many ways. Outcome measures will place the profession on a sound scientific base. They will provide a means of measuring, demonstrating, and monitoring the effectiveness of occupational therapy. This will improve the credibility of the profession with clients, other professionals, the community and governments, and will provide political strength for the development of the profession. Outcome information will provide a mechanism for occupational therapists to demonstrate the effectiveness, efficacy and efficiency of occupational therapy. This information will provide evidence of the quality of occupational therapy to accreditation boards, peer review groups and other health professionals.

This report represents the first steps toward the development of outcome measures of the client-centred practice of occupational therapy. The report focusses on <u>what</u> outcome measures are and <u>how</u> they might be developed for occupational therapy. The scope of the project was limited to the formation of recommendations for the development of outcome measures for occupational therapy. The actual design, development and testing of an outcome measurement tool for occupational therapy were outside the scope of this project. Two main sources of information were used by the Task Force: 1) information gained from a survey of occupational therapists practising in Canada; and 2) information gained from a review of the literature.

In addition, the Task Force agreed that in gathering and reviewing information on patterns of practice in occupational therapy, it should attempt to clarify the linkages between process elements in the practice of occupational therapy and outcome constructs of occupational therapy. The survey was designed to obtain information from a representative sample of occupational therapists concerning their perceptions of the outcomes of occupational therapy based on their actual clinical practice. The survey also obtained information on the respondents' background and their knowledge of the two guideline documents produced by earlier task forces.

CHAPTER II: BACKGROUND

1. REVIEW OF QUALITY ASSESSMENT AREAS

As the practice of occupational therapy has expanded and diversified, the quality of this practice has become of critical importance. Governments and institutions are questionning, evaluating and comparing health care delivery mechanisms. Thus, it is becoming increasingly important for health care disciplines and specific health care programs to provide evidence of the quality of care provided. The most effective evidence requires measures to judge quality. Occupational therapists themselves are interested and concerned with the quality of care provided and have begun to search for methods of measuring and improving quality of care at the client, program and institutional levels.

In discussions of the quality of care, the terms quality assessment and quality assurance are frequently used. Quality assessment refers to measurement of the degree or level of quality of service or care provided at a given point in time. It does not necessarily connote a commitment to change or improve that level of care (Rosenthal, 1977). Quality assurance refers to a promise that a certain level or standard of care will be provided and connotes a commitment to improving or maintaining care. The Task Force has chosen to focus on the development of quality assessment outcome measures.

Quality of care can be assessed in three areas: structure, process and outcome of care (Donabedian, 1966). Initially most quality assessments of health care programs focussed on structural factors including outputs* (not outcomes) of therapy. This assumed that if staff were qualified, facilities were adequate, and good staff-client ratios were maintained and hours of therapy were adequate, quality care would be assured and could be assumed. However, the quality of care cannot be determined by structure alone. While structural

*See pages 45, 46 for definitions

factors may increase or decrease the likelihood of quality of care and outcomes (Donabedian, 1980), once minimum levels of quality of stuctures are achieved, process factors will influence quality.

Process factors include the quality of referral, assessment and intervention procedures, and the quality of the client-therapist relationship and communication. Process factors are much more difficult to assess than structural factors. Chart audits frequently are employed to assess process factors of care. However, such audits can only determine if certain procedures and processes were followed, not how well they were performed. For example, a chart audit can determine whether the records show that an assessment was performed, problems identified and a program planned. The chart audit cannot determine the quality (i.e., if the assessment was thorough or conducted in a caring fashion).

The measurement of outcomes provides a third approach to assessing quality of care. According to Donabedian (1966), ... "outcome measures are the ultimate validators of the effectiveness and quality of medical care (p. 168)". These measures examine what happens to clients as a result of therapy and in this sense represent the "bottom line" of an intervention.

In summary, each of these areas -- structure, process, and outcome -- can be viewed as interacting factors in the quality of care. Quality in each area may be viewed as a necessary but not sufficient component of overall quality of care.

2. HISTORICAL BACKGROUND

Quality assessment and quality assurance have been topics of concern to occupational therapists for many years. Interest in quality of the occupational therapy practice stems in part from the sincere concern of occupational therapists to provide quality care and in part from external pressures on the discipline to evaluate and demonstrate the quality of care provided.

Over the past 15 years, significant work has been done on the development of structure and process quality assessment guidelines and procedures in occupational therapy. This work has been undertaken by the Canadian Association of Occupational Therapists (CAOT), and by the joint task forces of Health and Welfare Canada and CAOT. The work of the current Task Force represents the continuation and progression from this earlier work on structure and process. Structure, process and outcome measures already developed in occupational therapy are described below along with a brief historical review of activities relevant to each area of quality assessment. Little work has focussed on quality of care outcome measures in occupational therapy.

Measures of Structure - Structural aspects of quality of care include staff-client ratios, qualifications of staff, the adequacy of equipment and facilities and the outputs of therapy in hours, numbers of clients seen and numbers of services provided.

- In 1966, the CAOT in conjunction with Statistics Canada and Health and Welfare Canada developed a unit value statistical system to record and report staff activities and utilization rates of occupational therapy services. This standard system permits the assessment of staff-client ratios within and between facilities. The system has been subsequently revised and is widely used in institutions.

- In 1973 the CAOT developed standards for occupational therapy services which were later used by the Canadian Council on Hospital Accreditation. These standards cover structural criteria concerning facilities, record-keeping procedures and staff qualifications.

- In 1977, a CAOT task force developed a Skills Profile identifying the skills and competencies required of an occupational therapist. This was revised in 1980 and retitled Occupational Therapist - Occupational Profile.

Measures of Process - Process aspects of quality of care cover the process stages of referral, assessment, planning, intervention, discharge, follow-up and evaluation.

- The unit value system developed jointly by CAOT, Statistics Canada and Health and Welfare Canada in 1966, provides information on utilization rates. These data can be used in assessing the process of intervention.

- In 1979, responding to a request by CAOT, Health and Welfare Canada convened a Task Force which in 1983 produced Guidelines for the Client-Centred Practice of Occupational Therapy. This work on guidelines is particularly noteworthy since it:

  - provides a consensus definition of the process of occupational therapy practice;

  - provides a national framework of common goals and clinical processes for occupational therapy practice in Canada;

  - includes a glossary of key terms; and

  - provides a base for the development of process standards (as opposed to guidelines) of care.

  The document contains general national guidelines for the client-centred practice of occupational therapy and specific guidelines for assessment and treatment planning.

- In 1980, the Corporation Professionalle des Ergothérapeutes du Québec along with the Department of Labour and Manpower developed a set of occupational therapy profile guidelines. These guidelines provide an analysis of process tasks in occupational therapy.

- In 1984, a second joint CAOT and Health and Welfare Canada Task Force was formed which in 1986 produced Intervention Guidelines for the Client - Centred Practice of Occupational Therapy. This document provides specific national guidelines for practice regarding intervention, discharge, follow-up and client-centred program evaluation. It is particularly noteworthy because it:

- directly follows upon Guidelines for the Client-Centred Practice of Occupational Therapy, thus completing detailed generic process guidelines for the profession; and

- addresses the need for quality assessment and outcome guidelines.

Measures of Outcome - Quality assessment outcome measures consider the consequences, results and impacts of occupational therapy.

- To date there are no agreed upon outcome measures or guidelines for the development of outcome measures for occupational therapy.

With national structure and process guidelines in place for occupational therapy, the present Task Force has turned its attention to the development of quality of care guidelines for outcome measurement and, following that, to the development of a measurement tool(s) to measure occupational therapy outcomes. The task force (1986) which produced intervention guidelines recommended that "research be supported on the effectiveness of occupational therapy practices and procedures" (p.viii). This project represents the first phase in the development of an outcome measurement tool for occupational therapy. This Task Force was convened in 1986 by CAOT and Health and Welfare Canada to develop recommendations and guidelines for the development of outcome measures for occupational therapy.

CHAPTER III: ISSUES IN OUTCOME MEASUREMENT IN OCCUPATIONAL THERAPY

1. DEFINITION

Outcomes of therapy refer to the consequences, results or impacts of a therapy program. Outcomes refer to both the intended and unintended results of a therapy program. Client outcomes can be measured and reported on a client, program or institution basis. For example an outcome in activities of daily living (ADL) as a result of an intervention program might be that the client is completely independent in ADL. At the program level, ADL outcomes might be that out of 30 clients in a stroke program, 10 are completely independent in ADL. At the institutional level, a chronic care hospital might report that 3% of its clients are completely independent in ADL, 62% require the assistance of one person and 35% are completely dependent in ADL.

An outcome of therapy may involve prevention of dysfunction, or the development, restoration or maintenance of function in the client. For example for clients with diseases which result in progressively increasing disability, maintenance or a slowing of deterioration would be an expected and desired outcome. For others at risk (due to aging, lifestyle, occupation, etc.), prevention of dysfunction is a desirable outcome of occupational therapy. For those with temporary disability, restoration may be the expected outcome. And for children or adults who have potential to learn new skills, developing function may be the expected outcome of therapy.

Outcome measurement involves the use of systematic or scientific methods to determine client outcomes. The use of systematic and scientific methods refers to the use of standardized, valid and reliable measurement approaches which enable one to attribute outcomes to therapy.

2. OUTCOME GOALS IN OCCUPATIONAL THERAPY

Outcomes should be measured in relationship to the main goals of occupational therapy. Earlier task forces have identified four intervention goals. These are to prevent dysfunction, and to develop, restore and maintain function (Health and Welfare Canada and CAOT Task Force, 1986).

Keeping these goals of occupational therapy in mind, the primary outcomes of occupational therapy can be identified in the three performance areas of: self-care, productivity and leisure. Secondary outcomes can be identified with respect to the four performance components of: physical, mental, socio-cultural, spriritual. These secondary outcomes should be measured in terms of their contribution to the attainment of the primary outcomes of occupational performance in the context of the client's environment, motivation and roles.

In occupational therapy, these goals are met through the unique use of purposeful activities and the application of activity analysis.

3. MEASURING OUTCOMES IN OCCUPATIONAL PERFORMANCE

In describing outcome objectives of occupational therapy, reference was made to measuring occupational performance. Key features of occupational performance which are relevant to its measurement become clear when <u>occupational performance</u> is contrasted with functional ability, functional potential, and functional performance.

Occupational therapy has traditionally been functionally oriented. Several aspects of function can be assessed:

- functional <u>ability</u> refers to what the client is able to or <u>can do</u> in terms of functional activities;
- functional <u>performance</u> refers to what the client <u>does do</u>; and
- functional <u>potential</u> refers to what the client <u>would be able to do</u> with therapy, assistive devices or other support.

Occupational performance focusses on functional performance (i.e. what the client does do) but also examines this performance in relation to the client's environments, motivation and roles. The relevance of functional performance to the motivation and role requirements of the client and the environment of the client is an essential feature of occupational performance which should be captured in the measurement of occupational therapy outcomes.

A case example illustrates the differences between the concepts defined above. A male with an above-knee amputation, functioning in the area of meal preparation, may have the functional ability to prepare simple meals if all ingredients are in easy reach at counter level. He may have the functional potential to become completely independent in meal preparation if provided and trained with a prosthesis (enabling improved balance in reaching supplies in upper cupboards). In terms of functional performance, he may be completely dependent on his spouse who prefers to look after meal preparation. In occupational performance, meal preparation is not part of his role requirement and thus has low incentive in his motivation. Outcome measures developed should assess all aspects of occupational performance as this is the primary objective of occupational therapy.

4. OUTCOME MEASURES IN CONTRAST TO CLIENT ASSESSMENT AND OTHER MEASURES

Outcome measures are used to assess the qualitative and quantitative impacts of therapy. Outcome measures of occupational therapy should be distinguished from output and process measures of therapy. Outputs of therapy refer to the quantitative services produced by occupational therapists and distributed outside the service or program (i.e. the concrete activities of therapists that can be counted). Examples of outputs include hours of therapy provided, reports produced, splints made, etc. They do not represent results or impacts of therapy, but rather measurement of the workload or volume of services produced. Process measures are used to examine the procedures of care (referral, assessment, program planning, intervention, discharge, follow-up,

evaluation as outlined in the two volumes of guidelines previously published). Process measures determine whether the process stages occurred, and, as in quality assurance reviews, whether the procedures conducted in each stage of the process meets a given standard.

Outcome measures may also be contrasted with other types of assessment measures. While outcome measures are used to determine the results of therapy, client assessments are usually conducted for the purposes of referral, placement, program planning, and follow-up. Outcome measures focus primarily on measuring the impacts of therapy. General assessments collect broader diagnostic and program planning information.

Outputs and utilization rates are frequently combined for groups of clients and submitted in monthly or quarterly statistical reports, while assessment and process measures are usually charted.

On individual client records, assessment information is collected to provide data for program planning; process information is recorded to document intervention; and outputs are counted to document program activities. However, outcomes are rarely measured in a consistent fashion in occupational therapy. Information on impacts or outcomes of therapy is not usually available in a standard format. Outcome measures would complete this data base on occupational therapy, providing a comprehensive feedback loop of information.

5. ATTRIBUTING OUTCOMES TO OCCUPATIONAL THERAPY

A key to the measurement of outcomes of occupational therapy is determining and defining the outcomes of therapy. A common approach to the measurement of outcomes is to first identify areas of performance or function on which therapy is assumed to have an effect, and then measure performance in those areas.

However the ability to attribute changes in these areas to the effect of occupational therapy alone is limited by several factors. First, there are no unique outcomes resulting only from occupational therapy. Performance areas such as self care may also be affected by other therapeutic interventions including physiotherapy, respiratory therapy, and medicine. Second, changes in outcome areas may occur independent of any therapeutic intervention, as a result of a natural maturation or recovery process. Third, other intervening factors may affect outcome. For example, the sudden death of a spouse may have a greater effect on performance outcomes than does therapy. Outcomes can be attributed to occupational therapy when appropriate design, methodology and statistical techniques are used to control, analyse and/or identify these factors. The use of such design and statistical controls (see Cook and Campbell, 1979) in evaluating the outcomes of occupational therapy can increase the confidence with which one can conclude that the measured outcomes were the result of occupational therapy.

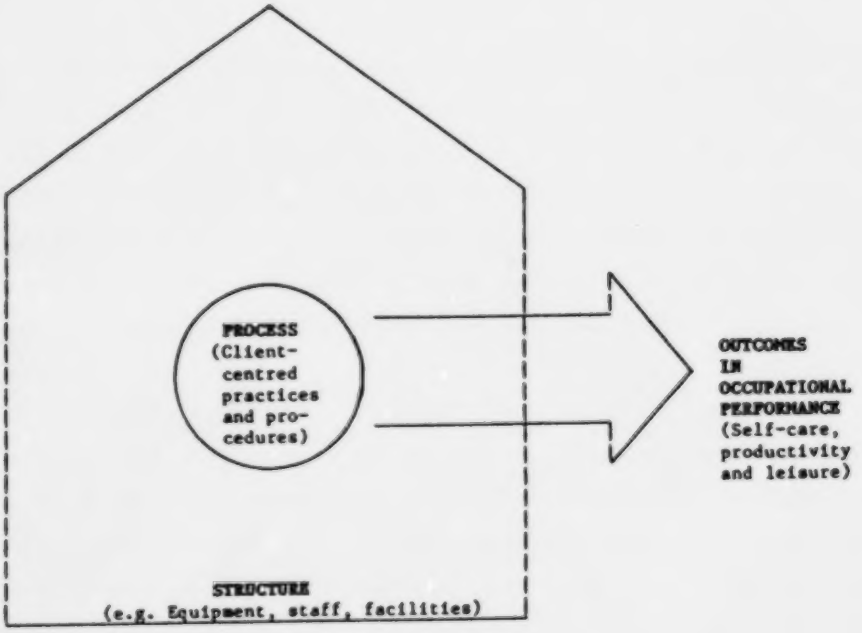
6. A CONCEPTUAL FRAMEWORK FOR QUALITY ASSESSMENT IN OCCUPATIONAL THERAPY

A conceptual framework showing the relationship of the three areas of quality assessment and a conceptual model of occupational performance is presented in Figure 1. In this framework, structural features of care provide the resources and structure within which the process of therapy occurs. Process of therapy includes referral, assessment, program planning, intervention, discharge, follow-up and program evaluation.

The structure of the therapy program and process of therapy together with the application of the model of occupational performance contribute to and affect outcomes of therapy. These outcomes are the result of the interaction of the structure and process of care. For occupational therapy, structure, process and outcome of quality of care are described in detail in the document

Guidelines for the Client-Centred Practice of Occupational Therapy (Health and Welfare Canada and CAOT Task Force, 1983). The broad outcome arrow in Figure 1 is intended to indicate that outcomes may occur in any or all areas of occupational performance (self care, productivity and leisure) and in all components (physical, mental, socio-cultural and spiritual). Inadequacies in the structure or process of care will affect the outcome obtained. For example, inadequate facilities or equipment will affect outcomes because the process of care occurs within the structure of the therapy program.

FIGURE 1: CONCEPTUAL FRAMEWORK OF QUALITY ASSESSMENT AREAS



CHAPTER IV: LITERATURE REVIEW

1. MEASUREMENT CONCEPTS

Before reviewing the literature on outcome measures, general measurement concepts and issues of concern in evaluating measurement tools are presented. It is desirable to identify existing tools that could be used for outcome measurement of occupational performance. To review existing tools and their potential as outcome measures, several factors should be considered. These include the sensitivity, purpose, population specificity, measurement format, reliability and validity of the tool and the measurement approach used. Each of these factors is discussed in greater detail below.

a) Sensitivity. In order to be useful in practise, an outcome measure should be sensitive to variations in outcome that are considered clinically important. Reliability and validity do not ensure that important differences in functioning can be detected. In fact reliability and sensitivity are often inversely related. There are many ADL scales/instruments available which meet relevant reliability and validity standards. These scales typically involve the rating of ADL components on a scale indicating the degree to which an individual can perform an activity independently (such as 1 = completely independent; 2 = requires supervision; 3 = requires assistance of one person; and 4 = completely dependent). However the tool may not be sufficiently sensitive or specific to record change.

Consider the case of a client referred for occupational therapy who on assessment is found to require assistance to transfer to the tub for bathing. The transfer may be accomplished in an unsafe manner with much physical strain on the family caregiver. As a result, the client rarely bathes. Through the input of occupational therapy a tub grab bar is installed, the family caregiver and client are trained in safe transfer techniques, and the client begins

bathing regularly. On most scales of functional status no change in ADL outcome would be measured, because the client continues to require the assistance of one person in this activity. This case illustrates the need to consider that the sensitivity of existing tools should be reviewed.

b) Purpose. Measurement tools used in occupational therapy may be developed for any of a variety of purposes such as diagnosis, screening, prognosis, treatment planning, classification or placement. Some tools are used primarily as a device for communicating with clients, families or other professionals. The purpose for which a tool has been developed affects the scope, type of items and areas covered by the tool. For this reason, measurement tools developed for other purposes may not be appropriate for outcomes measurement. For example, on a treatment planning measurement tool, it is important to obtain information concerning the reasons for dysfunction. On an outcome measurement tool the level or status of the client is of greater concern than the reasons for the client's status. Law (1986), in discussing criteria for selecting a measurement tool for occupational therapy, emphasizes the importance of the purpose of the tool.

c) Specificity. Some tools are developed for use with very specific client populations. Tools are frequently developed for specific diagnostic or problem groups (e.g. psychiatry -- Azima Battery, Azima, 1961; Comprehensive Occupational Therapy Evaluation Scale, Brayman et al., 1976; mental retardation -- Avocational Picture Interest Inventory, Kavanagh et al., 1985; hand injury -- Hand Sensitivity Test for the Hypersensitive Hand, Yerxa et al., 1983; vocational rehabilitation -- Functional Assessment System for Vocational Rehabilitation, Crewe et al., 1984; specific skill problem groups -- Assessment Scale of Oral Functions, Ottenbacher et al., 1985; specific age groups -- Prone Extension Postural Test, Gregory-Flock and Yerxa, 1984, Play History Interview, Takata, 1969; or clients in specific settings, e.g. elderly living in the community -- Natural Support System Assessment Tool, Gross-Andrew and Zimmer, 1978.

Tools developed for a specific population may not be useable or easily adapted for use with other occupational therapy client populations.

d) Measurement Format. Many different approaches can be used in measuring outcomes. In a single performance area such as self-care, outcomes can be measured using self-report of status, activity logging, recording observation, clinician assessment, standardized performance testing, interview or family reporting approaches. The approach used may affect the results obtained. In a clinical setting, often a combination of approaches is used. Although self-report measures of functional status have been compared with clinician and family assessments, less research has been conducted on the validity and effects of other measurement approaches such as observation of task performance used in occupational therapy.

Kaufert (1979) found close agreement between self-report and clinician assessed measures of functional ability. Agreement was highest for less complex activities and lowest for more complex activities. Similarly, Jellinek et al. (1982) found self-report measures to be reliable and valid measures of functional ability, and Moss et al. (1982) report close agreement between self-reported and family member assessment's of client's functional status. On the other hand, Cook (1983) comparing vocational rehabilitation client and work evaluator ratings of vocational competence and status found that work evaluators rate client vocational competence significantly lower than do the clients.

Some performance areas or components can only be measured by using a certain approach. For example internal feelings and attitudes, and qualitative measures of pain are usually self-reported, while joint range of motion is usually clinician assessed since therapist expertise is required. In general, the self-report approach is less costly than other measurement approaches. Activity logging is time consuming for clients and, depending on the situation, may be rejected or not completed by clients. Observation and standardized

performance testing are also time consuming approaches. Often it is difficult to observe the client functioning in a normal environment for sufficient lengths of time to ensure comprehensive measurement of functioning. Likewise, standardized performance tests usually test a limited sample of functional behaviour and are conducted in a controlled setting that may not include influences which affect the client's functioning in his usual environment. Clinician assessment (direct measurement and interviews) can usually cover a wide range of components of performance in a fairly cost effective manner. For these reasons, self-report and clinician assessment approaches tend to be the most frequently used. However the potential biases of the approach used should be carefully considered.

e) Reliability. Reliability refers to the consistency of a tool in measuring a given attribute. Consistency over time within raters and between raters is desirable. Test-retest reliability refers to consistency of measurement over time. Intra-rater reliability refers to consistency of measurement repeated by the same person. Intra-rater reliability is a component of test-retest reliability focusing on the consistency attributed specifically to the rater rather than to the random daily changes related to the client, the environment, or the test itself. Inter-rater reliability refers to the consistency of scores obtained when different raters or therapists use the same tool with the same client.

A measurement system for quality assessment should be highly reliable with respect to both test-retest, intra-rater and inter-rater reliability. Outcome measures should ideally reflect the client's occupational therapy outcome and not be overly susceptible to minor fluctuations.

Test-retest reliability can be determined by administering the measures on two occasions. Obviously the length of the interval between the successive administrations affects the level of reliability. If the interval is very short and the same occupational therapist administers the measurement system on

both occasions, the client's or therapist's memory of the previous assessment may affect the reliability. If the interval is very long, clients may undergo real changes. Thus an intermediate length of interval, balancing these two concerns, is desirable.

Intra-rater reliability is also determined through repeated testing. Attention is paid to obtaining maximum consistency for the client and the environment. Therapists with varying experience or working in varying situations may then administer the measure on two occasions, the same time apart for each therapist.

Inter-rater reliability is typically examined in either of two ways. First, one may have two or more different therapists or raters independently assess the same clients and examine inter-rater reliability and agreement among the raters. Alternatively, one can adopt a "gold standard" approach and have a therapist and an expert measurement team or individual independently assess a sample of clients. Inter-rater reliability and agreement between the assessing therapist and an expert or standardization team are then calculated statistically.

A tool should be reliable if it is to be used to assess the quality of care and outcomes achieved.

f) Validity. In addition to the reliablity of the measurement system, its validity should also be established before it can be implemented and used with confidence. Validity refers to the extent to which the tool measures what it is intended to measure. Several types of validity may be considered:

- Content validity. Content validity refers to whether the measures cover the full scope of each outcome area of performance specified for measurement in the purpose of the test.

- Criterion-related validity. Criterion-related validity indicates the extent to which the measures obtained using the tool agree with another valid criterion measure.

- Construct validity. Construct validity refers to the extent to which the measurement tool measures a theoretical construct or trait.

- Face validity. Face validity refers to the extent to which the measurement tool appears on subjective review to measure what it purports to measure.

The validity of a tool is closely related to the reliability or consistency of the tool in measuring what it intends to measure. A tool should be valid if it is to be used to assess the quality of care and outcomes achieved.

2. REVIEW OF OUTCOME MEASUREMENT IN OCCUPATIONAL THERAPY LITERATURE

In this section, occupational therapy literature on the measurement of occupational performance and outcomes of occupational therapy is reviewed in order to describe measures currently used, to identify appropriate quality of care outcome measures, and/or to suggest ways of developing such measures.

In reviewing the occupational therapy literature very few outcome studies were found, but there are a large number of articles on the development and testing of assessment tools. This is not surprising since valid, reliable measures of performance are needed before outcome studies can be conducted. The outcome studies assessed very specific outcomes of occupational therapy for which there were available tools. For example, Shillam et al. (1983) evaluated the effect of occupational therapy on bathing independence. Comparing before and after therapy measures of bathing using the Klein-Bell ADL Scale, they report that all 19 clients in the study showed improvement in bathing independence.

The recent literature on measurement in occupational therapy has focussed on the development of new tools (Florey and Michelman, 1982; Kielhofner, 1986b;

Stratton, 1981; Wilson et al., 1984; Yerxa et al., 1983); the refinement of existing tools in terms of standardization of the terminology and protocol (Smith et al., 1985) or quantification of scales (Parmenter, 1983); the evaluation of the reliability and/or validity of existing tools (Ottenbacher et al., 1985; Gregory-Flock and Yerxa, 1984; Behnke and Fetkovich, 1984; Nelson et al., 1984; Petersen et al., 1985; Harlowe and Van Deusen, 1984); and the development of norms for performance on existing tools (Ager et al. 1984; Bissell and Clark, 1984; Bowman and Katz, 1984; Punwar, 1982; Mandell et al., 1984; Mathiowetz et al. 1985; Schwartz et al. 1984a, Schwartz et al., 1984b; Zemke, 1985).

All of these measurement tools assess very specific performance components, or secondary outcomes of occupational therapy. Tools assess components such as oral functions (Ottenbacher et al. 1985; Stratton, 1981); grasp and pinch strength (Bowman and Katz, 1984; Smith and Benge, 1985); postrotary nystagmus (Nelson et al., 1984); and figure perception (Petersen et al., 1985). They do not address the primary outcomes of occupational therapy: occupational performance in the areas of self-care, productivity and leisure. As such, secondary outcome measures of performance components are of value in assessment and treatment planning but are not useful in assessing outcomes in occupational performance. Grip strength is an important assessment measure and is usually considered in treatment planning. However many aspects of performance (particularly mental, socio-cultural and spiritual) do not have reliable and valid methods of outcome measurement.

While little research has focussed on outcome measurement related to the model of occupational performance, there has been considerable research on the model of human occupation (Kielhofner, 1986a, 1986b). This research has involved comparative studies examining differences between client groups on variables from the model, correlational studies of variables associated in the model and instrument development studies of tools for the assessment of variables from the model (Kielhofner, 1986a). Of particular interest are measurement tools

developed to assess client roles and occupational functioning -- client factors also of importance in the model of occupational performance. The Role Checklist (Oakley, 1982) is a paper and pencil inventory to assess perceived incumbency and value attached to roles in the past, present and future. The Occupational Role History, (Moorehead, 1969; Florey and Michelman, 1982) uses an interview format and 33 open-ended questions to screen for dysfunction in occupational role activities of physically disabled clients. There is an optional rating scale which can be used to quantify measures on the tool. The Assessment of Occupational Functioning (Watts et al., 1986) is a screening tool for dysfunction which is designed for long term care clients and uses a briefer set of interview questions. The Care Analysis Interview and Rating Scale (Cubie and Kaplan, 1982; Kaplan, 1984) is an interview and rating scale designed for clients with acute psychiatric illness. The Index of Occupational Behavior (Gregory, 1983) designed for the elderly, is an index of self-report ratings of amount and meaningfulness (enjoyability, autonomy and competency) of 23 common activities. Oakley et al. (1985) describe a Rating Continuum for Clinical Judgement of the Organizational Status of the Human System. This is a 5-point summary scale completed by the therapist after a thorough assessment of components from the model of human occupation. Initial studies on all these indicate sufficient reliability to warrant further use and evaluation.

Overall, there has been scant research to date on the outcomes of occupational therapy as outlined previously. Research on measurement tools has focussed on the development of many performance component measurement tools for occupational therapy. Recent research has also been directed at the development of measures of variables from the model of human occupation. While some of these may be of potential use in assessing outcomes, further work on their reliability and validity is needed. Most of these measures of occupational role and behaviour have been developed and tested on very specific client groups and would need to be modified for use with a general client

population. Many outcome areas do not have appropriate measurement tools, and there are no guidelines for the development of these tools.

To date, there have been no reports in the literature of outcome measures based on the model of occupational performance presented in the report Guidelines for the Client-Centred Practice of Occupational Therapy. This does not mean that there are not many existing tools for the measurement of performance or function in the areas of self-care, productivity and leisure. In fact some tools do exist, but have not been identified or developed as measures of occupational performance in these areas as conceptualized in the model of occupational performance.

3. REVIEW OF LITERATURE ON PERFORMANCE AREA MEASUREMENT IN OCCUPATIONAL THERAPY AND OTHER FIELDS

This section reviews measurement tools and the general literature on measures in each of the three primary outcomes: the areas of performance identified in the model of occupational performance (i.e. self-care, productivity, and leisure).

Self-Care. Self-care performance refers to performance with respect to personal care and household management activities. As noted in Chapter III: 3. Measuring Outcomes in Occupational Performance, the concept of occupational performance links function with environment, motivation and role requirements. There are many tools for the measurement of activities of daily living covering personal care and more complex home management or instrumental activities of daily living.

Recent reviews of functional assessment instruments (Bruett and Overs, 1969; Donaldson et al., 1973; Granger and Gresham, 1984; Halpern and Fuhre, 1984; Israel et al., 1984; Kane and Kane, 1981; Staisey and Wudwud, 1986) indicate that many reliable, objective assessment tools are currently available. The

American Occupational Therapy Association (1984) produces lists of standardized tests reported in use by occupational therapists. The tools available vary in terms of assessment purpose, activities covered, assessment approach, length, reliability and validity. While these instruments represent a solid basis for the development of a quality care outcome assessment tool, several factors limit their use without modification as outcome measures of self-care for occupational therapy.

First, most tools measure functional ability in self-care as opposed to performance. There are many widely used tools for measuring functional ability in self-care (including the Barthel Index, Mahoney and Barthel, 1965; Function Status Index, Reynolds, et al., 1974; Katz Index of ADL, Katz et al., 1963; Kenny Revised Self-Care Index, Schoening et al., 1968; Patient Evaluation Conference System - Occupational Therapy Scale, Harvey and Jellinik, 1983). Only a few tools have been developed to measure functional performance. These include the Comprehensive Evaluation of Basic Living Skills (Casanova and Ferber, 1976), the Rehabilitation Indicators' Status Indicators and Activity Pattern Indicators (Brown, Gordon and Diller, 1984; Diller, Fordyce and Jacobs, 1981), and the Longitudinal Functional Assessment Inventory (Rintala et al., 1980, 1984).

Second, many tools have been developed for specific client groups such as clients with psychiatric illness (Comprehensive Evaluation of Basic Living Skills, Casanova and Ferber, 1976), and elderly clients (Geriatric Functional Rating Scale, Grauer and Birnbon, 1975).

Finally, none of the tools measure performance in self-care in relation to the client's environment, motivation and role requirements. The problems of gender bias in assessing instrumental or complex activities of daily living such as meal preparation, laundry, have been frequently noted in the literature (Lawton, 1972; Kane and Kane, 1981). Despite the fact that traditional role activities in home management differ for men and women, few household or

instrumental activity of daily living scales distinguish between performance which is role required and that which is not role required. On the Philadelphia Geriatric Centre Instrumental Activities of Daily Living Scale (Lawton et al., 1982) both performance and ability to perform activities are rated and the client is asked why he/she does not perform or does not need to perform each activity. While this tool may identify an activity not performed because it is not a role requirement (e.g. a man who does not prepare meals because it has always been his wife's responsibility), environment, motivation and role requirements are not specifically assessed or recorded on the tool.

For these reasons, available tools do not meet the requirement for an outcome measurement tool of occupational performance in self-care. The main shortcoming of current tools is a failure to clearly measure performance as opposed to ability and a failure to measure occupational performance in relation to environment, motivation and role requirements.

Productivity. Productivity performance refers to performance of activities or tasks which are done to enable the person to provide support to the self, family and society through the production of goods and services (Health and Welfare Canada and the Canadian Physiotherapy Association, 1979). In the broader sense, productivity performance is the performance area which covers the activities and roles which give meaning and purpose in life. In children, the productivity role may be fulfilled through play and schoolwork; in adults and the elderly, through employment or volunteer activities. There are a wide variety of measures of performance of productivity activities. Most of these have been designed for prevocational assessment purposes. Generally three categories of productivity measures are used in occupational therapy: specific component skill measures; work sample measures; and, vocational interests measures. Measure of specific component skills include the Crawford Small Parts Dexterity Test, the Minnesota Rate of Manipulation Test, the O'Conner Tweezer Dexterity Test, and the Purdue Peg Board Test. These tests assess specific manual skills and are used primarily in treatment planning and

monitoring. Such tests are not appropriate outcome measures in productivity since they cannot measure actual results or consequences of therapy with respect to productivity.

Work sample measures are also often employed for assessment and treatment planning purposes. These tools assess client performance in a simulated work situation, on a sample of work activities involved in a specific job. The Valpar and the Microtower Group Vocational Evaluation Systems contain work sample tests for a variety of jobs such as message taking and making change. Again these tests cannot measure actual outcomes in productivity.

Interest measures are often used to assist a client in choosing a new occupation. The Strong Campbell Interest Inventory and the Jackson Vocational Interest Survey are designed for this purpose. Again, these measures do not tap performance of productivity activities.

Research on vocational rehabilitation frequently uses indicators such as employment status (full-time, part-time, unemployed) as an outcome measure. Cook (1983) categorized vocational outcomes of rehabilitation in terms of ... "successfully rehabilitated working; successfully rehabilitated but not working (e.g. rehabilitated as homemaker or unpaid family worker); or not rehabilitated" (p.47). This measure assesses general performance of productivity functions and counts return to unpaid yet productive employment as a positive outcome. However it does not take into account the role appropriateness of productivity performance. Thus, individuals who are underemployed relative to their abilities and qualifications would score the same as those appropriately employed.

Kemp and Vash (1971) measured productivity performance outcomes of spinal cord injured clients by abstracting information from follow-up interview notes and having it rated by experienced judges on a 5 point scale ranging from not

productive (1) to most productive (5). The reliability of this measurement approach has not been assessed.

In summary, few outcome measures of productivity performance are available. Employment status measures have been used as measures of outcome in productivity performance, but employment status measures usually do not take into account the environment, motivation or role relevance of productivity performance.

Leisure. Leisure refers to components of life which are free from work and self-care activities. Leisure may be assessed in terms of interests, attitudes, skills or frequency of involvement. What is considered leisure as opposed to productivity may vary with the personal meaning of the activities and the developmental stage of the individual. For a child, play may be viewed as productivity that is the developmental "work" of childhood. Likewise, volunteer activities may be viewed either as leisure interests by a young adult, or as productivity activities by a retired person for whom volunteer activities are meaningful "work" for the community.

Both objective and subjective measures of leisure are available. Objective measures of leisure time and involvement include reported time and frequency measures of leisure activity. Diaries or logs have been used to record leisure performance (Bishop et al., 1975; Szybillo et al., 1979). A problem with the use of such logs is that individuals tend to differ in their definitions of leisure time. Another option is to use a recall approach in which clients self-report performance of time and frequencies or performance of leisure activities. However, individuals, again, may vary in their recall and definition of leisure time.

Interest checklists provide another approach to measuring leisure. Matsutsuyu (1969) developed the Neuropsychiatric Institute Interest Checklist for use in occupational therapy. This checklist contains 80 common leisure activities.

The client rates interest in each activity on a scale of strong, casual, or no interest. Interests not contained on the list can be added and rated at the bottom of the form.

Subjective measures of leisure include ratings of interest, preferences, enjoyment, satisfaction, involvement and competency in leisure activities. Specific activities may be rated on each of these factors. A difficulty in assessing performance in leisure is the wide individual variation in leisure activities and interests. In measuring performance in self-care, it is not difficult to develop a generic list of self-care activities which are relevant for most individuals. This task is far more difficult for leisure activities. In summary, further work is needed to develop occupational performance outcome measures in the area of leisure performance.

CHAPTER V: REPORT ON THE CURRENT PRACTICE SURVEY OF THE FREQUENCY AND IMPORTANCE OF OUTCOMES IN OCCUPATIONAL THERAPY

A mailed questionnaire survey of a representative sample of occupational therapists was conducted by this Task Force to provide information on the frequency and importance of outcomes in occupational therapy. The survey collected information on therapists:

- education, experience, work settings and client caseloads;
- perceptions of the outcomes of occupational therapy based on their actual clinical practice; and
- knowledge of the Guidelines produced by earlier task forces (1983, 1986).

1. METHODOLOGY

a) Questionnaire. A questionnaire with sections covering each of the above was developed and pretested prior to mailing (see Appendix 1). In order to identify relevant outcomes of occupational therapy, a list of potential outcomes was developed. Specific outcomes were identified for each of the areas of occupational performance (self-care, productivity and leisure) and component areas (physical, mental, socio-cultural, and spiritual). Space was provided under an "other" category for therapists to describe additional outcomes which were not listed. Therapists were asked to rate (on a 1 to 5 scale) how frequently they see changes in clients on each outcome. In addition they were asked to rate the importance of each outcome on a similar 1 to 5 scale.

b) Sample. A random sample of 200 occupational therapists was drawn from the 1986-87 membership lists of the CAOT and the Corporation des Ergotherapeutes. Therapists in all provinces except Quebec were selected from the CAOT membership list. Therapists in Quebec were selected from the Corporation membership list, as this was felt to provide a more complete listing of

occupational therapists in Quebec. While neither source provides an exhaustive list of occupational therapists in Canada, they provide a more comprehensive list than is available from any other source.

c) Method. The survey questionnaire was mailed to the sample of 200 therapists along with a cover letter signed by the Task Force Coordinator and Chairperson, and a stamped return envelope (see Appendix 1). Therapists living in Quebec received these materials in both English and French. Two weeks after the first mailing a follow-up reminder letter was sent by the Task Force researcher to all respondents who had not returned a completed questionnaire (see Appendix 1).

d) Response rate. An excellent response rate was obtained. Out of the 200 questionnaires mailed, 156 completed questionnaires were returned, 10 were returned marked wrong address or moved with no forwarding address. This represents an overall response rate of 78%. The questionnaires were completed well with minimal missing data.

2. RESULTS

A summary of responses to the survey are provided on the questionnaire in Exhibit 1 on the following pages.

a) Survey sample characteristics. The survey respondents appear to be representative of occupational therapists in Canada. Although demographic information on the population of occupational therapists is not available, the respondents to the survey are similar to those responding to earlier larger surveys.

Almost half (46%) of those surveyed were between 20 and 29 years of age. The average number of years experience of therapists surveyed was 11 years (S.D. = 14.93).

EXHIBIT 1: QUESTIONNAIRE ON THE OUTCOMES OF OCCUPATIONAL THERAPY

SECTION A

First, we would like some basic background information about you and where you work.

1. Please check your age below.

46%	20 - 29
37%	30 - 39
7%	40 - 49
6%	50 - 59
3%	60 - 69
0%	70 or above
1%	Missing

2. Please indicate your sex.

3%	1. Male
97%	2. Female

3. How many years have you worked directly using your skills an an occupational therapist?

11 years (SD = 14.93)

4. Please indicate your education.

30%	1. Dip. O.T
75%	2. B.Sc.O.T., B.A., B.Sc.
5%	3. M.A.
1%	4. Ph.D.

5. What is your current employment status as an occupational therapist?

64%	1. Full-time
25%	2. Part-time
3%	3. Casual or temporary basis
8%	4. Not currently working as an occupational therapy - If not currently working as an occupational therapist go to Section C.

6. Do you see clients on a regular basis?

90% 1. Yes
10% 2. No If no, go to Section C.

7. In what type of program do you work?

18% 1. Psychiatry
80% 2. Other than Psychiatry
2% Both

8. In what type of setting do you work?

35% 1. Acute care institution
18% 2. Long term care institution
25% 3. Rehabilitation facility
12% 4. Home care
7% 5. School
14% 6. Other Community - Describe _____
11% 7. Other - Describe _____

9. Please describe the type and age of clients which make up the bulk of your caseload.

16% Children (0-18 years)
18% Adult
20% Elderly
29% Mixed
16% Not applicable
1% Missing

The following questions concern the outcomes (that is, the impacts or effects) of occupational therapy. Outcomes may represent positive change, effective prevention, or maintenance of the client. In answering the questions, think specifically of the clients you typically treat during a month and in which you feel your therapy has an impact. Be sure to circle an answer to every item using the two scales provided.

	10. As a result of your therapy how frequently do you see changes or impacts in your clients in the following areas? 1 Never 2 3 4 5 Always 8 N/A						11. Please rate the importance of changes, as they contributed to overall functioning of the client, in each of the following as an outcome of occupational therapy? 1 not at all important 2 3 4 5 extremely important 8 N/A						INDEX* SCORE
	mean response indicated by boldface						mean response indicated by boldface						
	%	%	%	%	%	%	%	%	%	%	%	%	
Self Care/Personal Care													**12**
- dressing	5	22	17	36	12	7	3	9	13	27	41	8	14
- bathing	14	18	22	34	3	9	10	7	17	28	30	8	12
- grooming	10	18	24	33	6	9	4	7	16	30	33	9	13
- toileting	14	16	21	34	6	10	9	3	9	21	48	10	13
- transferring	19	9	20	27	13	11	16	1	13	18	42	10	13
- ambulation	16	18	24	28	3	11	14	5	13	18	41	9	12
- eating/feeding	8	18	22	32	13	7	5	4	11	18	54	8	15
- sexuality	36	31	19	4		10	21	6	27	21	16	9	7
Household Management													**7**
- telephone use	25	30	19	12	1	12	18	15	22	19	16	11	8
- driving	44	22	15	6	1	13	33	13	18	13	11	13	6
- shopping	27	26	24	8	1	13	18	14	31	20	4	13	7
- meal preparation	20	7	17	38	6	12	15	6	14	29	24	12	12
- housework	22	18	21	26		13	19	11	28	20	10	13	9
- handyman work	35	28	15	9	1	13	34	15	20	14	5	12	6
- laundry	29	28	19	12		13	23	21	26	11	7	13	6
- money management	36	21	18	12		13	24	11	21	19	13	13	7
- transportation use	23	29	21	14	1	12	14	13	22	27	13	12	8
Productivity													**7**
- employment potential	28	27	20	9	4	13	24	15	11	21	18	11	8
- physical capacity for employment	31	21	19	13	3	13	27	12	12	19	20	11	8
- practical employment skills	30	25	22	9	3	12	24	16	15	19	16	10	8
- interpersonal employment skills	32	24	16	15	1	12	29	13	17	15	15	11	7
- play for children	53	8	7	13	7	12	47	3	9	12	19	11	7
- developmental stage	48	11	8	15	7	12	40	6	10	16	17	12	7
- school skills	47	14	10	12	6	11	41	4	9	17	19	10	7
- potential for community/volunteer work	28	21	22	18	2	11	25	16	20	16	12	10	8
Leisure													**12**
- physical skills needed for participation in leisure activities/hobbies	7	16	33	29	10	6	7	8	18	37	24	6	13
- practical leisure skills	8	23	30	28	6	6	9	9	18	36	22	6	12
- interpersonal skills for leisure activities	7	25	33	23	7	6	7	11	24	28	25	6	11
- meaningful use of free time	9	23	31	24	7	7	7	7	21	34	25	7	12

*Boldface indicates average of outcome item index scores for the outcome areas.

	10. As a result of your therapy how frequently do you see changes or impacts in your clients in the following areas? (1 Never – 5 Always; 8 N/A)						11. Please rate the importance of changes, as they contributed to overall functioning, in each of the following as an outcome of occupation therapy? (1 not at all important – 5 extremely important; 8 N/A)						INDEX SCORE
	mean response indicated by boldface						mean response indicated by boldface						
	%	%	%	%	%	%	%	%	%	%	%	%	
Physical Condition													12
- range of motion	15	11	25	30	13	7	13	6	16	27	31	7	13
- strength	12	13	22	32	14	7	10	6	18	32	27	7	13
- endurance	7	12	21	37	16	7	7	6	17	29	35	7	14
- sensation	20	26	30	14	3	7	15	11	17	30	21	7	9
- coordination	11	15	21	36	11	7	10	9	13	32	30	7	13
- balance	16	13	23	32	9	7	13	7	8	34	32	7	13
- reflex activity	26	22	26	17	3	8	20	9	25	21	18	7	8
- sensory integration	26	17	25	18	6	7	20	6	22	25	21	7	10
- pain	18	19	28	25	3	7	14	5	20	20	35	7	11
- appearance	13	16	29	29	7	7	12	11	16	30	25	7	12
Mental													12
- mood/affect		15	26	43	12	5	1	3	16	35	40	5	15
- cognitive skills	10	16	29	34	5	6	7	6	24	29	30	5	12
- coping	2	11	34	39	10	5	1	2	16	30	46	5	15
- perceptual skills	12	13	34	28	7	6	11	5	21	26	32	5	12
- behavior control/ appropriateness	9	18	29	33	6	5	7	4	17	33	34	5	13
- body image	10	13	33	34	6	5	8	6	18	33	30	5	13
- reaction/adaptation to dysfunction	3	12	37	33	10	5	3	3	17	27	45	5	14
- emotional skills	7	22	38	26	3	5	6	4	21	32	33	5	12
- self-concept	5	9	36	40	5	5	3	5	11	32	44	5	14
- drive/energy level	6	18	39	25	7	5	5	6	14	38	33	5	13
Socio-Cultural													11
- family relationship	7	29	34	22	2	7	6	7	20	24	36	7	12
- community involvement	12	35	28	16	2	7	8	15	22	32	16	7	9
- friendships	13	32	31	15	3	7	8	8	21	35	22	7	10
- roles and habits	10	18	41	21	3	7	7	8	22	34	24	7	11
Spiritual													9
- sense of well being	7	16	36	30	5	7	5	3	16	34	36	7	13
- vision of self	6	18	43	22	4	7	4	5	21	30	33	7	12
- meaning in life	15	26	33	17	3	8	10	9	18	26	30	7	10
- attendence at religious activities	50	27	13	3	1	7	39	22	17	10	4	8	4
- values	26	38	16	12	2	7	17	17	22	21	16	7	8
Other													
- describe: _____		10	10	29	14	38		5	5	5	48	38	
- describe: _____		8		17	8	67				8	25	67	

*Boldface indicates average of outcome item index across for the outcome areas.

SECTION C

The next questions concern a report titled "Guidelines for the Client-Centred Practice of Occupational Therapy". This report was produced by a Task Force on Occupational Therapy Guidelines convened by Health and Welfare Canada and the Canadian Association of Occupational Therapists.

12. Are you aware of the report, Guidelines for the Client-Centred Practice of Occupational Therapy?

87% 1. Yes

11% 2. No - If no, skip the remaining questions. Thank you for completing the questionnaire.

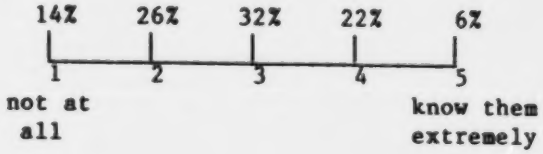
2% Missing

13. Have you read the Guidelines for the Client-Centred Practice of Occupational Therapy?

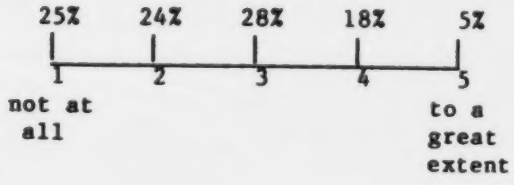
78% 1. Yes

22% 2. No

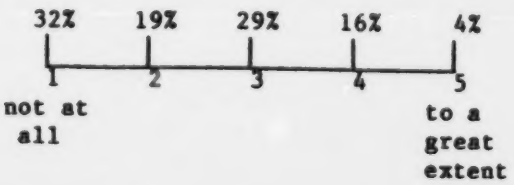
14. How knowledgeable are you of Guidelines for the Client-Centred practice of Occupational Therapy?



15. To what degree have you used the guidelines in your work?



16. To what degree have you used the model of occupational performance, as outlined in the Guidelines, in your work?



Almost all were female, and 75% had a B.Sc.O.T., B.A., or B.Sc degree. Most (64%) worked full-time as an occupational therapist. One quarter of those surveyed worked part-time. This is an increase in part-time employment as compared with other earlier surveys. Almost all (90%) of those who report current employment as an occupational therapist see clients on a regular basis. Only 18% of respondents work in psychiatric programs. Most (80%) work in other than psychiatric programs. Concern has been expressed recently over the relatively small number of therapists involved in psychiatric/mental health occupational therapy. The demographics of this sample underscore such concerns. Those surveyed report working in a variety of settings (35% in acute care institutions; 18% in long term care institutions; 25% in rehabilitation facilities; 33% in community settings such as home care, schools, etc., and 11% in other settings) with a wide variety of client groups. When asked to describe their caseload most responded with diagnostic (strokes) or anatomical categories (hands) as opposed to disability categories despite recent trends in the profession to move away from diagnostically-based practice.

b) Comparison with other surveys. The demographic characteristics of the sample are similar to those reported in other recent surveys of occupational therapists. For example, Madill (1985) conducted a survey of all CAOT members to assess career decisions and changes made by occupational therapsists. This involved a sample of 2,261 therapists, of whom 1,400 responded. Madill (1985) reports that 42% of those surveyed were between 20 and 29 years of age and almost all (96%) of the respondents were female. The findings of the current survey are very similar to these. While the objective of the Madill (1985) study reports that 68% had their Baccalaureate degree, a slightly higher percentage (75%) report having a Baccalaureate in the current survey. This may reflect the change to Baccalureate programs over the last decade and the tendency for diploma therapist to return to university to complete their degree.

c) Outcomes. The percentage of respondents using a particular rating score in rating each outcome is shown in Section B of Exhibit 1. Mean ratings for each outcome are shown (in boldface) in Section B of Exhibit 1. From these ratings

it can be seen that changes in self-care were rated as a moderately frequent and very important outcome of occupational therapy. This was true of all self-care outcome items with the exception of sexuality which rated as an infrequent outcome of moderate importance. Changes in the areas of household management and productivity were similarly rated. They were reported as an infrequent outcome of medium to little importance.

Household management and productivity were also more frequently rated as "not applicable" by the respondents, indicating either a lack of client need in these areas or a lack of focus on these areas by therapists.

Impacts on leisure, like self-care, were rated as moderately frequent and very important outcomes. Outcomes in the performance components (physical condition, mental, socio-cultural, and spiritual) were generally reported to be moderately frequent and very important outcomes. A few specific outcomes such as reflex activity, sensory integration, community involvement, attendance at religious activities and values were rated as less frequent and less important outcomes.

Index scores of outcome were calculated for each outcome item by multiplying the importance rating by the frequency rating. A summary index score for each outcome area was calculated by averaging the index scores on outcome items in the area. Self care and leisure have relatively high summary index scores of 12 as compared to household management and productivity (summary index score of 7). Of the performance components, physical, mental and socio-cultural have high summary index scores (12, 12, and 11 respectively) as compared to spiritual which has a summary index score of 9.

In summary, therapist ratings of outcomes indicate that current practice is directed at outcomes in the performance areas of self-care and leisure to a greater degree than in household management or productivity. In terms of

performance components, practice focusses on physical, mental and socio-cultural components to a greater degree than on the spiritual component.

d) Awareness and use of guidelines. The final section of the questionnaire concerned awareness and use of the Guidelines produced by earlier Task Forces (1983, 1986). A large majority (87%) of those surveyed reported being aware of the report on Guidelines, and 78% reported having read the Guidelines. In rating their knowledge of the Guidelines most reported moderate knowledge (3 on a scale of 1 to 5), fewer reported using them to a moderate or great extent, and a smaller number reported using the model of occupational performance outlined in the Guidelines. This is not surprising given the recency of the report and the time it takes for new concepts to become incorporated and used in clinical practice.

CHAPTER VI: RECOMMENDED CRITERIA AND APPROACHES TO THE DEVELOPMENT OF OUTCOME MEASUREMENT TOOL(S) FOR OCCUPATIONAL THERAPY

A major recommendation of this report is that a tool or set of tools (outcome measures) for occupational therapy be developed and tested. This chapter describes the following recommended criteria and approaches for doing this.

1. The tool(s) should be developed specifically for occupational therapy and testing should assess the degree to which it captures the important contributions of occupational therapy. To achieve this goal, criteria for the development of the tool(s) should be considered.

   Based on the results of the survey and the literature review, the following criteria for the development of outcome measures of occupational therapy have been identified. Outcome measures for the occupational performance areas addressed by occupational therapy should be:

   a) based on the model of occupational performance (as outlined in the Guidelines for the Client-Centred Practice of Occupational Therapy);

   b) focussed on the three areas of occupational performance (self-care, productivity, leisure) while recognizing the holistic contribution of the client's environment, motivation and roles, as well as performance components (physical, mental, socio-cultural and spiritual) required for a particular area of performance;

   c) sensitive to the outcomes identified as appropriate to occupational therapy given the model as a conceptual framework;

   d) sensitive to the three objectives of occupational therapy: to prevent change resulting in disability; to promote positive change by developing or restoring function; and to minimize negative change by maintaining function;

e) sensitive to clinical changes relevant and meaningful to the four goals of occupational therapy intervention: prevent dysfunction; develop, restore and maintain function;

f) not diagnosis specific;

g) recognizant of developmental levels and role variations;

h) incorporating measurement properties of reliability and validity;

i) usable in format in terms of time, administration, client acceptability, ease of scoring;

j) quantitative in sub-scores and final score;

k) modular for use in whole or in part;

l) usable as a data base for quality assurance; and

m) sufficiently flexible to measure the outcome of a variety of intervention approaches (e.g., rehabilitative, developmental, psychosocial, biomechanical).

2. Tools should be developed to cover the three areas of occupational performance (self-care, productivity, leisure). These areas will provide a starting point for the organization and design of the tools.

a) These tools should be developed using existing tools where available and modifying tools are needed.

b) Many tools exist to measure self-care but do not measure performance and not in relation to environment, motivation and role requirements.

c) In the case of leisure, appropriate existing tools do not appear to be available. In this case new tools should be developed to measure performance of children, working adults and retirees.

d) Few outcome measures of productivity are available and these fail to take into account environment, motivation and role requirements, and do not measure productivity performance.

e) The format of the tools in terms of self-report, performance and observation should be selected on an area specific basis in developing the tools.

3. The developed tools should be field tested in a diversity of occupational therapy programs.

a) Field test sites should be selected to represent a range of programs with respect to location and setting (e.g., institutional, community, urban, rural, geographic location, age groups and type of clients served).

b) Both out-patients and in-patients should be involved in field testing.

c) Initially the testing should be done in English only. The development of a tool(s) for use in a French environment presents complex cultural and translational problems when done from an English perspective. At this point, with the majority of occupational therapists working in an English environment, it is advisable to begin outcome measurement with development of an English test. Testing in a French environment should be done at a later stage.

4. It is recommended that the testing involve applying the tool(s) at two points in time with clients to assess outcomes.

a) The precise timing of measurement (e.g, at intake assessment, discharge or follow-up) should be selected based on the setting and program.

b) The test-retest, intra-rater and inter-rater reliability, and the validity of the tools should be assessed as part of the field test.

GLOSSARY OF TERMS USED IN THIS REPORT

For the purposes of its deliberations the Task Force defined the following terms associated with quality of care and outcome assessment as they would apply to occupational therapy.

ACTIVITY	A specific action, function or sphere of action that involves learning or doing by direct experience. (Reed and Sanderson, 1980).
ADAPTATION	Adjustment of an organism to its environment, or the process by which it enhances such fitness.
AREAS OF OCCUPATIONAL PERFORMANCE	Leisure - components of life free from work and self-care activities. Productivity - activities or tasks done to provide meaning and support to the self, family and society. Self-care - activities or tasks done routinely to maintain the client's health and well-being in the environment (Adapted from Reed and Sanderson, 1980)
ASSESSMENT	The process of collecting, analyzing and interpreting information, obtained through observation, interview, record review and testing.
CLIENT	A recipient of occupational therapy services.

COMPETENCE	The knowledge, skills, values and attitudes needed to properly carry out one's professional activities. (Butler, 1978).
CRITERION	A principle on which a judgement of quality may be based.
EFFECTIVENESS	The average benefit of a procedure when used by the average provider in the average community. (Rosenthal, 1977)
EFFICACY	The benefit (or lack of it) of a procedure or treatment when performed under ideal circumstances. (Rosenthal, 1977)
EFFICIENCY	The ratio of useful work performed to the total effort expended. (Rosenthal, 1977)
ENVIRONMENT	Cultural - ethos and value system of a particular people or group.
	Physical - natural and man-made surroundings of an individual and structural living space boundaries.
	Social - patterns of relationships of people living in an organized community.
EVALUATION	Program evaluation - the process of reviewing the results of action.

FUNCTIONAL ASSESSMENT	An evaluation of the integration of mental, physical, sociocultural, and spiritual states and their interaction in order to perform purposeful acts.
GOAL	The purpose or aim of a client's program or therapist's activities.
GUIDELINE	An outline from which standards or criteria can be developed to measure quality of care.
INTERVENTION	Process of interceding to affect functional change in occupational performance by the use of purposeful activity. It is influenced by the client's developmental stage, state of mind, current and expected health status, time, setting and the resources available.
MEASUREMENT	The act of assessing or estimating by some rule.
OBJECTIVE	A specific expectation or goal.
OCCUPATIONAL PERFORMANCE	Activities carried out by the client in the areas of self-care, productivity and leisure influenced by environmental and societal factors. (Reed and Sanderson, 1980)
OCCUPATIONAL PERFORMANCE COMPONENTS	Mental - total emotional and intellectual response of an individual to the environment.

Physical - motor skills and sensory functions. (Adapted from Reilly, 1969).

Sociocultural - dimension which describes the interpersonal relationships of a client with his family; and educational, ethnic and community backgrounds.

Spiritual - state of well-being; the force that permeates and gives meaning to all life.

OCCUPATIONAL THERAPY

Occupational therapy is the art and science which utilizes the analysis and application of activities specifically related to occupational performance in the areas of self-care, productivity and leisure. Through assessment, interpretation, and intervention, occupational therapists address problems impeding functional or adaptive behaviour in persons whose occupational performance is impaired by illness or injury, emotional disorder, developmental disorder, social disadvantage, or the aging process. The purpose is to prevent disability; and to promote, maintain or restore occupational performance, health and spiritual well-being. Furthermore, occupational therapy services can be directed through health, educational and social services systems.

OCCUPATIONAL THERAPY SERVICES

Organizational structure and system within which occupational therapy programs are provided. (American Occupational Therapy Association, 1979).

OUTCOME

Outcomes of therapy refer to the consequences, results or impacts of a therapy program. Outcomes refer to both

	the intended and unintended results of a therapy program. Client outcomes can be measured and reported on a client, program or institution basis. An outcome of therapy may involve prevention of dysfunction, or restoration, improvement, maintenance, or deterioration of function in the client. Outcome measurement both quantitatively and qualitatively involve the use of systematic or scientific methods to determine client outcomes. The use of systematic and scientific methods refers to use of standardized, valid and reliable measurement approaches which enable one to attribute outcomes to therapy.
OUTPUTS	Quantitative services or products provided by the therapist and distributed outside of the service or program.
PROCESS	The nature and sequence of actions and interactions (dynamic) of administered care. (Health and Welfare Canada and CPA, 1979).
QUALITY ASSESSMENT	Involves measuring the level of quality provided at some point in time; it connotes no effort to change or improve that level of care. (Rosenthal, 1977)
QUALITY ASSURANCE	Involves both measuring the level of care provided and when necessary improving it. (Rosenthal, 1977)
QUALITY OF CARE	The degree of excellence in the provision of services.
REASSESSMENT	Process of obtaining and interpreting data necessary for updating intervention goals and plans. (American Occupational Therapy Association, 1979).

STANDARD	Officially established level and its acceptable degree of variation. (Health and Welfare Canada and CPA, 1979).
STANDARDIZED TEST	A tool in which specific instructions and materials are used to evaluate a measurable behaviour, with a system for recording and scoring to allow comparison with a norm.
STRUCTURE	Organized patterns of social, economic, environmental, physical and human resources that create a milieu for health care. (Health and Welfare Canada and CPA, 1979).
TASK	A specific activity or job which is to be performed. The function that a working person is expected to fill. (Reed and Sanderson, 1980).
THEORY	System of assumptions, accepted principles and rules of procedure devised to analyze, predict or otherwise explain the nature of behaviour of a specific set of phenomena. (Reed and Sanderson, 1983).

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APPENDIX 1

SURVEY MATERIAL

Health and Welfare Canada
Santé et Bien-être social Canada

Health Services and Promotion Branch
Direction générale des services et de la promotion de la santé

APPENDIX 1-1

November 19, 1986

Your file Votre référence

Our file Votre référence

Dear Colleague:

As part of its Clinical Guidelines Program the Department of National Health and Welfare has been collaborating with health professions in developing national guidelines for clinical procedures. Through its task forces, this Program offers coordination and leadership in improving quality of health care, a goal common to the Department and the professions.

One such task force, a collaboration of the Department with the Canadian Association of Occupational Therapists, has been developing national guidelines for clinical practice in occupational therapy. Over the past six years this task force has produced two reports: "Guidelines for the Client-Centred Practice of Occupational Therapy" and "Intervention Guidelines for the Client-Centred Practice of Occupational Therapy".

Recently, the task force began working toward the development of measures to assess outcomes of occupational therapy. Such measures will give scientific direction to the profession and increase its degree of professionalization. In order to work toward this complex task, the Department has entered into a contract with Dr. Nancy Staisey, to begin by carrying out a survey to determine the characteristics of occupational therapy as it is practised across Canada. Dr. Staisey is an occupational therapist.

As the result of a random sample, you have been selected as one of 200 occupational therapists to participate in this survey. We invite your co-operation by filling in the attached questionnaire and returning it to Dr. Staisey in the next two weeks. For this purpose, a self-addressed, stamped envelope is enclosed.

We thank you in advance for the cooperation and assistance we hope to receive.

Eve Kassirer

Eve Kassirer, MA
Clinical Guidelines Program
Department of National Health
and Welfare
and Coordinator
Task Force on Outcome Measures
in Occupational Therapy

Thelma Gill

Thelma Gill, MEd, BScOT, OT(C)
Chairman
Task Force on Outcome Measures
in Occupational Therapy

Enc.

Ottawa, Ontario
K1A 1B4

Ottawa, Ontario
K1A 1B4

Canada

APPENDIX 1-2

Health and Welfare Canada
Health Services and Promotion Branch

Santé et Bien-être social Canada
Direction générale des services et de la promotion de la santé

RECEIVED

le 19 novembre 1986

Your file / Votre référence

Our file / Notre référence

Cher collègue,

Dans le cadre du programme de principes directeurs des activités cliniques, Santé et Bien-être social Canada a collaboré avec des spécialistes de la santé pour établir des principes directeurs nationaux à l'égard des méthodes cliniques. Par l'intermédiaire de ses groupes de travail, le programme assure la coordination et la direction des efforts visant l'amélioration des soins de santé, but que partagent le Ministère et les spécialistes.

L'un des groups de travail, constitué de représentants du Ministère et de l'Association canadienne des ergothérapeutes, a établi des principes directeurs à l'égard des activités cliniques de l'ergothérapie. Au cours des six dernières années, ce groupe a publié deux rapports: "Lignes directrices relatives à la pratique de l'ergothérapie axée sur le client" et "Lignes directrices régissant l'intervention en ergothérapie axée sur le client".

Récemment, le groupe de travail a commencé à travailler à l'établissement de mesures afin d'évaluer les résultats de l'ergothérapie. De telles mesures donneront à la profession une orientation scientifique et augmenteront son degré de professionnalisme. Afin d'atteindre ce but, le Ministère s'est assuré les services du Nancy Staisey (Ph.d) pour mener une enquête qui déterminera les caractéristiques de l'ergothérapie, telle qu'elle se pratique au Canada. Nancy Staisey est une ergothérapeute.

Vous avez été choisi au hasard pour faire partie des 200 ergothérapeutes qui participeront à cette enquête. Nous vous prions de bien vouloir remplir le questionnaire ci-joint puis de le retourner au Nancy Staisey dans les deux semaines à venir. Vous trouverez une enveloppe pré-adressée et affranchie.

Nous vous remercions à l'avance de votre collaboration et de votre aide.

Eve Kassirer

Eve Kassirer, M.A.
Programme de principes directeurs
des activités cliniques
Ministère de la Santé et du
Bien-être social
et coordinatrice du
Groupe de travail sur l'évaluation
des résultats en ergothérapie

Thelma Gill

Thelma Gill, M. Ed., B, Sc.
Présidente du
Groupe de travail sur l'évaluation
des résultats en ergothérapie

Ottawa, Ontario
K1A 1B4

Ottawa, Ontario
K1A 1B4

Canada

QUESTIONNAIRE ON THE OUTCOMES OF OCCUPATIONAL THERAPY

SECTION A

First, we would like some basic background information about you and where you work.

1. Please check your age below.

__ 20 - 29
__ 30 - 39
__ 40 - 49
__ 50 - 59
__ 60 - 69
__ 70 or above

2. Please indicate your sex.

__ 1. Male
__ 2. Female

3. How many years have you worked directly using your skills an an occupational therapist?

_____ years

4. Please indicate your education.

__ 1. Dip. O.T
__ 2. B.Sc.O.T., B.A., B.Sc.
__ 3. M.A.
__ 4. Ph.D.

5. What is your current employment status as an occupational therapist?

__ 1. Full-time
__ 2. Part-time
__ 3. Casual or temporary basis
__ 4. Not currently working as an occupational therapy - If not currently working as an occupational therapist go to Section C.

6. Do you see clients on a regular basis?

__ 1. Yes
__ 2. No If no, go to Section C.

7. In what type of program do you work?

__ 1. Psychiatry
__ 2. Other than Psychiatry

8. In what type of setting do you work?

__ 1. Acute care institution
__ 2. Long term care institution
__ 3. Rehabilitation facility
__ 4. Home care
__ 5. School
__ 6. Other Community - Describe _____
__ 7. Other - Describe _____

9. Please describe the type and age of clients which make up the bulk of your caseload.

_____
_____
_____

SECTION B

The following questions concern the outcomes (that is, the impacts or effects) of occupational therapy. Outcomes may represent positive change, effective prevention, or maintenance of the client. In answering the questions, think specifically of the clients you typically treat during a month and in which you feel your therapy has an impact. Be sure to circle an answer to every item using the two scales provided.

	10. As a result of your therapy how frequently do you see changes or impacts in your clients in the following areas? 1 (Never) 2 3 4 5 (Always)	11. Please rate the importance of changes, as they contributed to overall functioning of the client, in each of the following as an outcome of occupational therapy? 1 (not at all important) 2 3 4 5 (extremely important)
Self Care/Personal Care		
- dressing	1 2 3 4 5	1 2 3 4 5
- bathing	1 2 3 4 5	1 2 3 4 5
- grooming	1 2 3 4 5	1 2 3 4 5
- toileting	1 2 3 4 5	1 2 3 4 5
- transferring	1 2 3 4 5	1 2 3 4 5
- ambulation	1 2 3 4 5	1 2 3 4 5
- eating/feeding	1 2 3 4 5	1 2 3 4 5
- sexuality	1 2 3 4 5	1 2 3 4 5
Household Management		
- telephone use	1 2 3 4 5	1 2 3 4 5
- driving	1 2 3 4 5	1 2 3 4 5
- shopping	1 2 3 4 5	1 2 3 4 5
- meal preparation	1 2 3 4 5	1 2 3 4 5
- housework	1 2 3 4 5	1 2 3 4 5
- handyman work	1 2 3 4 5	1 2 3 4 5
- laundry	1 2 3 4 5	1 2 3 4 5
- money management	1 2 3 4 5	1 2 3 4 5
- transportation use	1 2 3 4 5	1 2 3 4 5
Productivity		
- employment potential	1 2 3 4 5	1 2 3 4 5
- physical capacity for employment	1 2 3 4 5	1 2 3 4 5
- practical employment skills	1 2 3 4 5	1 2 3 4 5
- interpersonal employment skills	1 2 3 4 5	1 2 3 4 5
- play for children	1 2 3 4 5	1 2 3 4 5
- developmental stage	1 2 3 4 5	1 2 3 4 5
- school skills	1 2 3 4 5	1 2 3 4 5
- potential for community/volunteer work	1 2 3 4 5	1 2 3 4 5
Leisure		
- physical skills needed for participation in leisure activities/hobbies	1 2 3 4 5	1 2 3 4 5
- practical leisure skills	1 2 3 4 5	1 2 3 4 5
- interpersonal skills for leisure activities	1 2 3 4 5	1 2 3 4 5
- meaningful use of free time	1 2 3 4 5	1 2 3 4 5

	10. As a result of your therapy how frequently do you see changes or impacts in your clients in the following areas? 1 Never 2 3 4 5 Always	11. Please rate the importance of changes, as they contributed to overall functioning, in each of the following as an outcome of occupation therapy? 1 not at all important 2 3 4 5 extremely important
Physical Condition		
- range of motion	1 2 3 4 5	1 2 3 4 5
- strength	1 2 3 4 5	1 2 3 4 5
- endurance	1 2 3 4 5	1 2 3 4 5
- sensation	1 2 3 4 5	1 2 3 4 5
- coordination	1 2 3 4 5	1 2 3 4 5
- balance	1 2 3 4 5	1 2 3 4 5
- reflex activity	1 2 3 4 5	1 2 3 4 5
- sensory integration	1 2 3 4 5	1 2 3 4 5
- pain	1 2 3 4 5	1 2 3 4 5
- appearance	1 2 3 4 5	1 2 3 4 5
Mental		
- mood/affect	1 2 3 4 5	1 2 3 4 5
- cognitive skills	1 2 3 4 5	1 2 3 4 5
- coping	1 2 3 4 5	1 2 3 4 5
- perceptual skills	1 2 3 4 5	1 2 3 4 5
- behavior control/ appropriateness	1 2 3 4 5	1 2 3 4 5
- body image	1 2 3 4 5	1 2 3 4 5
- reaction/adaptation to dysfunction	1 2 3 4 5	1 2 3 4 5
- emotional skills	1 2 3 4 5	1 2 3 4 5
- self-concept	1 2 3 4 5	1 2 3 4 5
- drive/energy level	1 2 3 4 5	1 2 3 4 5
Socio-Cultural		
- family relationship	1 2 3 4 5	1 2 3 4 5
- community involvement	1 2 3 4 5	1 2 3 4 5
- friendships	1 2 3 4 5	1 2 3 4 5
- roles and habits	1 2 3 4 5	1 2 3 4 5
Spiritual		
- sense of well being	1 2 3 4 5	1 2 3 4 5
- vision of self	1 2 3 4 5	1 2 3 4 5
- meaning in life	1 2 3 4 5	1 2 3 4 5
- attendence at religious activities	1 2 3 4 5	1 2 3 4 5
- values	1 2 3 4 5	1 2 3 4 5
Other - describe: _____	1 2 3 4 5	1 2 3 4 5
- describe: _____	1 2 3 4 5	1 2 3 4 5

SECTION C

The next questions concern a report titled "Guidelines for the Client-Centred Practice of Occupational Therapy". This report was produced by a Task Force on Occupational Therapy Guidelines convened by Health and Welfare Canada and the Canadian Association of Occupational Therapists.

12. Are you aware of the report, Guidelines for the Client-Centred Practice of Occupational Therapy?

    __ 1. Yes

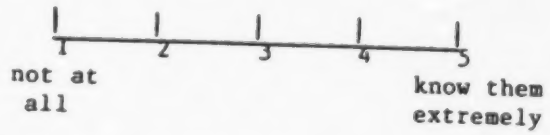
    __ 2. No - If no, skip the remaining questions. Thank you for completing the questionnaire.

13. Have you read the Guidelines for the Client-Centred Practice of Occupational Therapy?

    __ 1. Yes

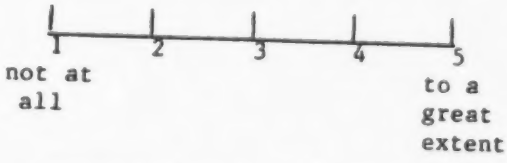
    __ 2. No

14. How knowledgeable are you of Guidelines for the Client-Centred practice of Occupational Therapy?



15. To what degree have you used the guidelines in your work?

16. To what degree have you used the model of occupational performance, as outlined in the Guidelines, in your work?



Thank you for your cooperation in completing the questionnaire. Please mail it immediately in the enclosed envelope.

QUESTIONNAIRE SUR LES RESULTATS DE L'ERGOTHERAPIE

SECTION A

Nous aimerions d'abord obtenir quelques renseignements de base à votre sujet.

1. Veuillez indiquer votre âge.

__ 20 - 29
__ 30 - 39
__ 40 - 49
__ 50 - 59
__ 60 - 69
__ 70 ou plus

2. Veuillez indiquer votre sexe.

__ 1. Homme
__ 2. Femme

3. Depuis combien d'années êtes-vous ergothérapeute?

_____ ans

4. Veuillez indiquer votre niveau de scolarité.

_____ 1. Dip.O.T.
_____ 2. B.Sc. ou B.A.
_____ 3. M.A.
_____ 4. Ph.D.

5. Quelle est votre situation actuelle en tant qu'ergothérapeute?

__ 1. A temps plein
__ 2. A temps partiel
__ 3. Occasionnel(le) ou temporaire
__ 4. Ne pratique pas l'ergothérapie à l'heure actuelle. Le cas échéant, passez à la section C.

6. Avez-vous des consultations régulièrement?

__ 1. Oui
__ 2. Non Sinon, passez à la section C.

7. Dans quel genre de programme travaillez-vous?

__ 1. Psychiatrique
__ 2. Autre

8. Dans quel genre de milieu travaillez-vous?

__ 1. Etablissement de soins aigus
__ 2. Etablissement de soins prolongés
__ 3. Service de réadaptation
__ 4. Soins à domicile
__ 5. Ecole
__ 6. Autre communauté - Précisez _____
__ 7. Autre - Précisez _____

9. Veuillez décrire le type de personnes qui composent en grande partie votre clientèle et indiquer leur age.

_____

_____

_____

SECTION B

Les questions suivantes ont trait aux résultats obtenus (c'est-à-dire aux conséquences ou aux effets) des traitements d'ergothérapie. Les résultats peuvent se traduire par l'amélioration, la prévention, ou la stabilisation de l'état du client. Pour y répondre, songez aux clients que vous traitez généralement pendant un mois et chez qui vous estimez que les traitements donnent des résultats. N'oubliez pas d'encercler une réponse pour tous les points mentionnés, selon l'échelle fournie.

	10. A quelle fréquence observez-vous chez votre client des améliorations pour les points suivants, à la suite des traitements? 1 Jamais 2 3 4 5 Toujours					11. Pour tous les points, veuillez indiquer l'importance des améliorations constatées à la suite des traitements? 1 Sans importance 2 3 4 5 Très importante				
Hygiène/soins personnels										
- habillage	1	2	3	4	5	1	2	3	4	5
- bain	1	2	3	4	5	1	2	3	4	5
- toilette	1	2	3	4	5	1	2	3	4	5
- aide pour se servir des toilettes	1	2	3	4	5	1	2	3	4	5
- transferts	1	2	3	4	5	1	2	3	4	5
- marche	1	2	3	4	5	1	2	3	4	5
- alimentation	1	2	3	4	5	1	2	3	4	5
- sexualité	1	2	3	4	5	1	2	3	4	5
Gestion du foyer										
- utilisation du téléphone	1	2	3	4	5	1	2	3	4	5
- conduite automobile	1	2	3	4	5	1	2	3	4	5
- emplettes	1	2	3	4	5	1	2	3	4	5
- préparation des repas	1	2	3	4	5	1	2	3	4	5
- travaux domestiques	1	2	3	4	5	1	2	3	4	5
- travaux manuels	1	2	3	4	5	1	2	3	4	5
- lessive	1	2	3	4	5	1	2	3	4	5
- gestion du budget	1	2	3	4	5	1	2	3	4	5
- utilisation des moyens de transport	1	2	3	4	5	1	2	3	4	5
Productivité										
- possibilités d'emploi	1	2	3	4	5	1	2	3	4	5
- aptitudes aux travaux manuels	1	2	3	4	5	1	2	3	4	5
- aptitudes en relations interpersonnelles liées à l'emploi	1	2	3	4	5	1	2	3	4	5
- jeux (enfants)	1	2	3	4	5	1	2	3	4	5
- stade de développement	1	2	3	4	5	1	2	3	4	5
- apprentissage scolaire	1	2	3	4	5	1	2	3	4	5
- possibilité de travail communautaire/bénévole	1	2	3	4	5	1	2	3	4	5
Loisirs										
- habiletés physiques requises pour participer à des activités récréatives ou pour s'adonner à certaines occupations	1	2	3	4	5	1	2	3	4	5
- sens pratique	1	2	3	4	5	1	2	3	4	5
- aptitudes en relations interpersonnelles pour s'adonner à des activités récréatives	1	2	3	4	5	1	2	3	4	5
- emploi rationnel du temp libre	1	2	3	4	5	1	2	3	4	5

	10. A quelle fréquence observez-vous chez votre client des améliorations pour les points suivants, à la suite des traitements? 1 Jamais 2 3 4 5 Toujours	11. Pour tous les points, veuillez indiquer l'importance des améliorations constatées à la suite des traitements? 1 Sans importance 2 3 4 5 Très importante
Condition physique		
- amplitude de mouvement	1 2 3 4 5	1 2 3 4 5
- force	1 2 3 4 5	1 2 3 4 5
- endurance	1 2 3 4 5	1 2 3 4 5
- sensibilité	1 2 3 4 5	1 2 3 4 5
- coordination	1 2 3 4 5	1 2 3 4 5
- équilibre	1 2 3 4 5	1 2 3 4 5
- activité réflexe	1 2 3 4 5	1 2 3 4 5
- intégration sensorielle	1 2 3 4 5	1 2 3 4 5
- douleur	1 2 3 4 5	1 2 3 4 5
- apparence physique	1 2 3 4 5	1 2 3 4 5
Etat mental		
- moral/affect	1 2 3 4 5	1 2 3 4 5
- faculté cognitive	1 2 3 4 5	1 2 3 4 5
- adaptation	1 2 3 4 5	1 2 3 4 5
- perception	1 2 3 4 5	1 2 3 4 5
- maîtrise/pertinence du comportement	1 2 3 4 5	1 2 3 4 5
- image corporelle	1 2 3 4 5	1 2 3 4 5
- réaction/adaptation au handicap	1 2 3 4 5	1 2 3 4 5
- protections émotives	1 2 3 4 5	1 2 3 4 5
- image de soi	1 2 3 4 5	1 2 3 4 5
- dynamisme	1 2 3 4 5	1 2 3 4 5
Aspect socio-culturel		
- relations avec la famille	1 2 3 4 5	1 2 3 4 5
- participation à la communauté	1 2 3 4 5	1 2 3 4 5
- relations avec des amis	1 2 3 4 5	1 2 3 4 5
- rôles et habitudes	1 2 3 4 5	1 2 3 4 5
Aspect spirituel		
- sentiment de bien-être	1 2 3 4 5	1 2 3 4 5
- vision de soi	1 2 3 4 5	1 2 3 4 5
- signification de la vie	1 2 3 4 5	1 2 3 4 5
- participation à des activités religieuses	1 2 3 4 5	1 2 3 4 5
- valeurs	1 2 3 4 5	1 2 3 4 5
Autre		
- précisez: _____	1 2 3 4 5	1 2 3 4 5
- précisez: _____	1 2 3 4 5	1 2 3 4 5

SECTION C

Les questions suivantes concernent les "Lignes directrices relatives à la pratique de l'ergothérapie axée sur le client", rédigées par le groupe de travail sur les lignes directrices en ergothérapie. Ce groupe de travail a été formé par Santé et Bien-être social Canada et par l'Association canadienne des ergothérapeutes.

12. Connaissez-vous les Lignes directrices relatives à la pratique de l'ergothérapie axée sur le client?

__ 1. Oui

__ 2. Non - Sinon, arrêtez-vous ici. Merci d'avoir rempli le questionnaire.

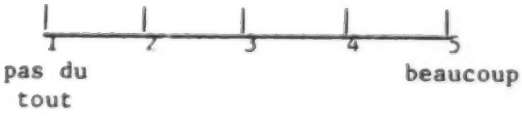
13. Avez-vous lu les Lignes directrices relatives à la pratique de l'ergothérapie axée sur le client?

__ 1. Oui

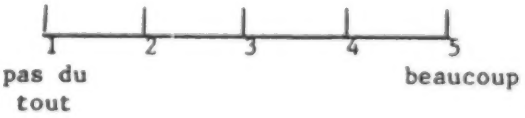
__ 2. Non

14. A quel point connaissez-vous les Lignes directrices relatives à la pratique de l'ergothérapie axée sur le client?

15. Dans quelle mesure avez-vous utilisé les lignes directrices dans votre travail?



16. Dans quelle mesure avez-vous utilisé le modèle de rendement au travail, décrit dans les lignes directrices, dans votre travail?



Merci d'avoir rempli le questionnaire. Veuillez le poster immédiatement dans l'enveloppe ci-jointe.

December 5, 1986

Dear Colleague:

Approximately two weeks ago I mailed you a questionnaire on behalf of the Task Force on Outcome Measures in Occupational Therapy. The purpose of the study is to determine the characteristics of occupational therapy as it is practised across Canada. We have not yet received your response. If you have already completed and mailed us your questionnaire, we thank you for your cooperation.

If you have not yet responded, I encourage you to do so as soon as possible. Your response will make an important contribution to the development of measures to assess outcomes of occupational therapy. We look forward to receiving your completed questionnaire and appreciate the effort you will devote to making this study a success.

If for any reason you do not currently have a copy of the questionnaire, please contact me at Price Waterhouse (613) 238-8200. A questionnaire will be forwarded to you immediately.

Thank you for helping to make this study a success.

Yours very truly,
PRICE WATERHOUSE

Nancy Staisey, Ph.D., OT.(C)
Manager

Le 5 décembre 1986

Cher Collègue,

Il y a deux semaines, nous vous avons envoyé un questionnaire d'enquête au nom du groupe de travail sur l'évaluation des résultats en ergothérapie du Ministère de la Santé et du Bien-être social. Si vous l'avez déjà rempli et nous l'avez renvoyé, veuillez ne pas tenir compte du reste de cette lettre. Nous vous remercions de votre collaboration.

Si vous n'avez pas encore répondu à notre questionnaire je vous encourage à le faire le plus tôt possible. Votre réponse aiderait toutefois le groupe de travail sur l'évaluation des résultats en ergothérapie.

Nous espérons recevoir bientôt votre questionnaire rempli et vous remercions à l'avance pour votre contribution à cette étude. Si, pour une raison quelconque, vous n'avez pas actuellement d'exemplaire de questionnaire, veuillez communiquer avec Mme Nancy Staisey à Price Waterhouse, (613) 238-8200. Un questionnaire vous sera expédié immédiatement.

Je vous remercie de votre participation au succès de cette étude. Veuillez agréer l'expression de mes sentiments distingués.

Sincèrement vôtre,
PRICE WATERHOUSE

Nancy Staisey, Ph.D., OT.(C)
Directrice